PSR SCHOOL HEALTH SERVICES
EMERGENCY MEDICAL AUTHORIZATION
ST. MARK CATHOLIC CHURCH 2024-2025

Student Name _____

Street Address _____

Grade _____ Phone _____

Purpose: To enable parents/guardians to authorize treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached. **This form MUST be returned by the first day of class.**

PART I OR PART II MUST BE COMPLETED

PART 1 – TO GRANT REQUEST

In the event that reasonable attempts to contact me at _____ (Phone) or _____ _____ (Other Parent) at _____ (Phone) have been unsuccessful, I hereby give my consent for:

1. Administration of any treatment deemed necessary by Dr. _____ (Doctor) or Dr. _____(Dentist) or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist;
2. Transfer of my child to _____(Hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.
Facts concerning my child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

_____

_____

Sign _____Date_____Phone_____

Address_____

PART II - REFUSAL TO CONSENT

(Do not complete part II if you have completed part I)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the school authorities to take no action or to:

_____

_____

Sign_____Date_____Phone_____

Address_____
(06/17)